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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ADELAIDA LIM ELAMPARO** **15455 Hidden Valley Drive** **Poway, CA 92064** **Registered Nurse License No. 417216** Respondent.	Case No. 2013-292 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 31, 1987, the Board of Registered Nursing issued Registered Nurse License Number 417216 to Adelaida Lim Elamparo (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2013, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
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> . . . .

REGULATORY PROVISIONS

7. Title 16, California Code of Regulations, section 1442, states:

> As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

8. Title 16, California Code of Regulations, section 1443, states:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and

experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

9. Title 16, California Code of Regulations, section 1443.5, states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COSTS

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

11. Respondent has subjected her registered nurse license to disciplinary action for unprofessional conduct under section 2761, subdivision (a)(1) in that she was grossly negligent, as defined by Title 16, California Code of Regulations, section 1442, as follows. Respondent was

working as an RN in the Sub Acute Unit at Palomar Pomerado Health. On July 1, 2010, at 0840, Respondent was notified by Radiology that her patient RM had a new moderate to large left pneumothorax. She requested the Radiology Department print out the report to the Sub Acute Unit printer and returned to another patient to complete a lower priority procedure that she had already commenced. She did not report the information to the Nurse Practitioner (NP) and/or the Physician. The report printed at 0924 hours. At 0930, 50 minutes after the initial report, the report was discovered by a NP still sitting in the unit printer. The NP asked Respondent why she had not notified her immediately of the report, and Respondent responded that she had just received the report ten minutes prior. She also documented that she had received the initial notification at 0845, when the Radiology Department made the call at 0840. The patient was transferred to the emergency room where a chest tube was inserted for further assessment and immediate care of the pneumothorax.

12. The standard of practice in a situation when a nurse receives contact from the radiology department that a patient has a new pneumothorax is to immediately assess the patient, notify the physician or provider, and document.

13. Respondent should have immediately called the physician/ provider as soon as she received the report. Respondent's conduct delayed care to this patient. Respondent's actions were grossly negligent in that she failed to exercise ordinary precautions in a single situation which she should have known could have jeopardized the patient's health.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

14. Respondent has subjected her registered nurse license to disciplinary action for unprofessional conduct under section 2761, subdivision (a)(1) in that she was incompetent, as defined by Title 16, California Code of Regulations, section 1443, as follows. On February 12, 13, and 14, 2011, Respondent was assigned to work the day shift in the Sub Acute Unit and was assigned to resident KC. KC reported to the NP that Respondent did not perform assessments of her condition on these days. When the NP asked Respondent, she admitted that she did not perform her own nursing assessments on those days, but documented that she did. In fact,

Respondent plagiarized her notes from the Respiratory Therapists documentation, thus falsifying medical records. Respondent exposed her patient KC to significant harm.

15. The standard of practice for nursing assessments is to perform an assessment on each patient on each shift. The assessment should be objective and subjective if applicable. A head to toe assessment that includes vital signs, skin integrity, breathe sounds, bowel signs, mobility, and level of consciousness. The documentation reflects the nurse's findings at the time of assessment.

16. By not performing assessments, critical changes in the patient may not have been discovered or treated in a timely manner, causing a delay in care. Respondent's conduct demonstrated incompetence in that she failed to exercise the care ordinarily possessed and exercised by a competent registered nurse.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

17. Respondent has subjected her registered nurse license to disciplinary action for unprofessional conduct under section 2761, subdivision (a)(1) in that she was grossly negligent, as defined by Title 16, California Code of Regulations, section 1442, as follows: On March 7, 2011, Respondent gave the wrong antibiotic to patient MM. Cefotoxin 1 gm IVPB was ordered and documented in the file. However, it was discovered later that an empty bag of Ancef IVPB was hanging on the IV pole. Respondent later admitted to administering Ancef. The Ancef had been discontinued 5 days prior.

18. The standard of practice for medication administration is to check the 5 R's: Right patient, right medication, right dose, right route, and right time.

19. Respondent administered the wrong medication because she failed to follow the medication safety guidelines. Confirming the 5 R's with the physician order sheet would have prevented the medication error. Respondent's conduct was grossly negligent in that she failed to exercise ordinary precautions in a single situation in which she should have known she could have jeopardized the patient's health.

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FOURTH CAUSE FOR DISCIPLINE

(Incompetence)

20. Respondent has subjected her registered nurse license to disciplinary action for unprofessional conduct under section 2761, subdivision (a)(1) in that she was incompetent, as defined by Title 16, California Code of Regulations, section 1443, as follows. On March 7, 2011, Respondent inaccurately documented an assessment on patient JS. She documented the patient was on oxygen, when the patient was on room air. She documented that the patient had total dependency for mobility. In other documents she made contradictory reports. In fact, the patient required little to extensive assistance. Also on March 7, 2011, Respondent failed to document that patient JS's G-Tube site had redness and granulation tissue surrounding the stoma, which was subsequently assessed as cellulitis. This resulted in a delay in care for the G-Tube site. The treatment for cellulitis would have started sooner if Respondent had done the assessment when she came on shift. On the following day, Respondent admitted to her inaccurate documentation. On March 17, 2011, Respondent was terminated from the hospital.

21. The standard of practice for nursing assessments is to perform an assessment on each patient on each shift. The assessment should be objective and subjective if applicable. A head to toe assessment that includes vital signs, skin integrity, breathe sounds, bowel signs, mobility, and level of consciousness. The documentation reflects the nurse's findings at the time of assessment.

22. By not performing assessments, and accurately documenting her findings, critical changes in the patient may not have been discovered or treated in a timely and appropriate manner, causing a delay in care and significant harm. In so doing, she demonstrated incompetence in that she failed to exercise the care ordinarily possessed and exercised by a competent registered nurse.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 417216, issued to Adelaida Lim Elamparo;

2. Ordering Adelaida Lim Elamparo to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: October 15, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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